FATALITY REVIEWS

PROGRAM AREA REPORT

(January 1, 2000 to December 31, 2000)

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FATALITY AND CRITICAL INJURY REVIEWS

One aspect of the mandate of the Children's Commission is reviewing child fatalities and critical injuries. In fulfilling this role, we

- collect and review information about every child death that occurs in the province,
- investigate those deaths where the adequacy of services to children or public health and policy is an issue,
- make recommendations, based on these investigations, to enhance the safety and protection of children.

The Vital Statistics Agency and the B.C. Coroner's Service inform us of every child death in B.C. After reviewing basic information about each death, we decide whether to undertake a review to determine the adequacy of services to the child (including medical services, the justice system and the school system) and to examine public health and policy matters. All unexpected deaths are fully reviewed, as are the deaths of all children in care of the government or receiving services from the Ministry for Children and Families (MCF). When a child in care has died, we check to ensure that MCF has complied with legislation and policy in protecting and parenting the child while it has been acting as the child's guardian. We also review some expected deaths in order to examine the quality of services and relevant public policy issues.

How We Conduct Fatality Reviews

During our fatality reviews, we focus on identifying practice, policy and service delivery issues in child-serving systems and making recommendations for constructive change.

First we examine all relevant source documentation. This might include police investigation reports, coroner's reports, medical records, records of service from health and social service agencies, and school records. We also write to the child's parents to notify them of our review and to invite them to provide input if they wish to do so.

The Children's Commission Act and the Inquiry Act empower us to obtain any information we need to conduct a review. Generally, we experience no difficulty in receiving the information we need in order to carry out comprehensive reviews.

Individuals who have been involved in providing services to the child or who were involved in investigating the death are interviewed as required. Parents are key informants in some cases. Site visits are made as required.

The review process may occur over a period of a few weeks or a period of several months, depending on the complexity of the review and other investigations or proceedings being conducted in relation to the death.

Analysis of Fatality Reviews

1. Trends in Child Fatality Statistics

There was no significant change in the total number of child deaths in British Columbia or the rate of deaths, which takes into account the number of children in the province, between 1999 and 2000.

Over the longer term, as noted in previous Annual Reports, both the number and rate of child deaths in the province has decreased, despite an overall increase in the total population of children and youth (see Table 1 attached). A significant factor in this decrease has been a decrease in the number of infant deaths. For example, between 1988 and 2000, the annual number of infant deaths in the province fell from 356 to 148, and there was a decrease in the death rate from 8.36 per 1,000 to 3.66 per 1,000 over this time period (see Tables 2 and 3 attached). This was apparently due to a decrease in deaths from Sudden Infant Death Syndrome (SIDS), better prenatal care for expectant mothers, and better care of infants after delivery.

While these data show a promising trend, we have significant opportunities to reduce these rates even further.

2. Fatality Review Statistics

Disposition of Fatality Files by Age and Time Period

Between January 1, 2000, and December 31, 2000, 363 deaths of children and youth were reported to the Commission. (Note this is a slightly higher number of deaths than recorded by the Vital Statistics Agency because out of province deaths of BC children and deaths of out of province children in BC are included in Commission counts but not in Vital Statistics Agency counts.)

Reviews are being conducted in 215 of these 363 deaths (decisions to review are pending in 12 cases). This section provides a detailed analysis of our findings.

Completed Fatality Reviews

Since its inception on September 26, 1996, the Children's Commission has completed and released to the public 554 fatality reviews, including 137 reviews completed in 2000. Tables 4, 5 and 6 attached provide a statistical summary of these reports.

An additional 13 reviews have been completed but are being held back from public release pending finalization of criminal or other review processes.

When the Children's Commission was first established, 140 deaths of children in care or known to the former Ministry of Social Services from July 1992 to September 1996 were passed over to us for full review. All of these have now been completed and released to the public.

Recommendations Resulting from Fatality Reviews

In the past year, we made 101 recommendations as a result of our completed reviews of the deaths of 137 children and youth during this period.

We believe that many of the deaths of other children and youth are preventable if our recommendations are implemented and result in changes to policies, practices and programs. The Children's Commission monitors responses to all of our recommendations so that we can determine if needed changes are being made. In monitoring responses to our recommendations, we track both those oriented to specific cases and those that address systemic issues to assess the progress of implementation.

These 101 recommendations can be broadly grouped into eight categories of key issues that affect the health and safety of children. Each key issue addresses the need for change in programs and policies relating to children and youth in this province:

Recommendation Category	Number of Recommendations
Integrated Case Management	19
Prevention and Early Support	18
Assessing and Reducing Risk	0
Information Sharing	23
Education and Training	13
Services to Youth	0
Services to Aboriginal Children and Youth	11
Safety and Injury Prevention	17
Total Number of Recommendations	**101**

The recommendations for change identified through the process of our fatality investigations clearly demonstrate that working to prevent the deaths of children and youth in British Columbia involves a change agenda that goes far beyond those services and programs of the Ministry for Children and Families and other parts of the provincial government. It requires leadership from health, education, community agencies, churches, business and labour to create safe communities for our children and youth.

While just over half of our recommendations have been made to various provincial ministries, offices and crown corporations, the remaining recommendations were addressed to a wide range of other bodies, including municipalities, health care agencies, police forces, schools and school districts, aboriginal bands, professional organizations and federal government departments. Public institutions and organizations, in the broadest sense, and local leaders in all communities and agencies have an important role to play in making our province a safer place for children.

Overall Response to Recommendations

The majority of responses received from ministries, agencies and other organizations to the recommendations made by the Children's Commission have indicated agreement with the content and direction of the recommendation, and have generally been comprehensive in nature. The majority of responses received indicate that the issues or concerns raised in the Commission's recommendations are taken seriously and are being, or will be addressed through actions outlined in the response.

Follow-up responses, received to date, also indicate that many of the Commission's recommendations have been partially to fully implemented. Some respondents have also indicated that they will continue to monitor the results or effectiveness of their initial implementation activities/strategies, and to implement further measures, if necessary, to create the desired change outlined in the content of the recommendation.

Notable Findings from Our Fatality Reviews

- In all 14 of the children in care who died, the children were taken into care in a timely manner.

- In 14 of the 15 cases in which the At Home program of the Ministry for Children and Families was involved, the service provided adequate support in a timely manner.

- Overall, child protection practise patterns seem to be improving over those observed in previous years' fatality reviews.

- Sufficient attention to early warning signs of future difficulty remains a challenge for the system.

- Aboriginal children remain over-represented in child deaths in B.C.

- Among youth who kill themselves, the most common factors observed included a history of depression, social isolation and alienation, substance abuse, ongoing family conflict, personal failure, school failure and humiliation.

- Some suicide deaths were related to conflicts experienced by immigrant youth adjusting to life in a new culture, and some youth who killed themselves had been subjected to bullying.

- In 11 of 15 youth suicides, people around the youth were aware of the youth being at risk of suicide.

- In 3 of the 5 homicides of young children reviewed, the children died at the hands of a parent, and in the other 2 cases, they died at the hands of another caregiver.

- Most motor vehicle deaths among youth are preventable through safe driving practices. Excessive speed, driver inexperience, failure to use safety restraints and impaired driving combine to kill youth on our streets and highways.

- In one-third of the youth motor vehicle fatalities reviewed this year, the driver was an underage impaired driver.

- In 8 of the 29 motor vehicle deaths reviewed, the driver was an unlicensed youth.

- In all 4 of the fire-related deaths reviewed this year, there were no operational smoke detectors in the homes.

- Inadequate safety measures and poor supervision by caregivers are the factors most associated with drownings and deaths during recreational activities.

Analysis of Fatalities

1. Children and Youth in Care

All deaths of children in care of the government are thoroughly reviewed by the Children's Commission. When government is acting as the legal parent of a child, and that child dies a full and public review is an important and necessary aspect of public accountability.

As children in care, these children have been removed from their natural parents. Most of these children have had extensive contact with service providers, either in the course of attempts to provide a safe environment in their homes or in the course of ongoing services while they were in care, or both.

The deaths of these children are often unrelated to their status as children in care. However, the review of the lives and deaths of these children provides a direct and powerful window into the world of professional and support services, and child protection practice.

Information from the Fatality Reviews

Of the 137 fatality reviews completed between January 2000 and December of 2000, 14 reported on deaths of children while they were in care of the government.

Many of these children spent much of their lives in care. In 8 of the cases, the children first came into care prior to the formation of the new Ministry for Children and Families.

All of the children who died while in care in the under 13 age groups were medically fragile children with significant ongoing special needs, and they died of complications of their medical conditions.

In all 14 cases the children were taken into care in a timely manner.

Table 7 shows the age groups of children in care that died.

Infants

Of the two infants who died in care in this age group, both were removed into care shortly after birth.

In both of these cases, the infants were removed as the result of their mothers' inability to care for them. In one case, the mother's mental illness prevented her from caring for the infant. In the other case, the mother was abusing substances and this prevented her from caring for the infant. Both

of these infants died while still in hospital due to complications as a result of extreme prematurity. In both of these cases, there is no record of the mothers having received prenatal care.

Age 1 to 5

Two children in this age group died while in care. One child was in care from birth because his mother felt that she could not provide the special care required to meet his significant medical needs. The cause of his death could not be determined. The other child in this age group was in care by agreement because his care could not be managed at home due to extensive special medical needs. He died a natural death related to his medical condition.

Age 6 to 12

Three children in this age group died while in care. All three of these children were in care under Special Needs Agreements due to special health care needs, and were in care for most of their lives. These children did not have specific terminal conditions; however, they died as a result of complications of their chronic severe health problems.

Age 13 to 18

Seven youth in this age group died while in care.

Four of these youths were in care under Special Needs Agreements due to special health care needs. Two of them had been in care most of their lives. Three of the youth died as a result of complications arising from their medical conditions, while the fourth youth died as a result of complications of a misplaced nasogastric feeding tube.

The other three youths in this age group who died while in care all died in motor vehicle incidents.

One of the youths was in care under a Voluntary Care Agreement in the last few months of life due to conflict with her family. Her placement was found to be inappropriate for her needs. Another of the youths was in care during the last 18 months of his life when his parents could no longer manage. He had been in care a total of 6 times during this time period, and lived most of that time in two different homes. In the third case, the youth had been in and out of care throughout most of his life. He was removed from his mother's care 5 times, initially as a result of parental neglect, and later as a result of conflict in the home. He had moved 14 times in the last year of his life, living in 7 different places, not including many short-term stays with relatives.

Recommendations Relating to Children and Youth in Care

Our reviews of 14 deaths of children in care of the government resulted in 11 recommendations. Six of these recommendations involved the review of some aspect of the medical care received by the child or youth prior to their death. Four concerned the need for review of policy and practice regarding special needs foster parents and their ongoing training and support. The last recommendation focused on information sharing within the medical community about the diagnosis of a particular medical situation.

Of the 11 recommendations, 4 were made to MCF, 4 were made to the BC College of Physicians and Surgeons and the remaining 3 were made to other medical facilities. This reflects the important roles played by MCF and the medical community in the lives of these children.

Overall, the response to these 11 recommendations has been positive, with all 30-day responses to the recommendations received.

For children and youth within the system to be well served, problems must be identified early on, proper interventions and supports must be put into place and all professionals that are involved in serving the child and family must work collaboratively and with full information, and always remain focused on the needs of the child.

2. *Children and Youth who had Received Services from the Ministry for Children and Families*

In addition to the 14 cases of children who died while in care of the government, there were 24 cases reviewed in which the Ministry had significant involvement in providing services to children who died.

There were another 6 cases in which the child or family had some superficial contact with the Ministry in the year before the death, and these cases are not included in the following discussion as a result (see Table 5).

In 15 of these 24 cases, the Ministry's involvement was largely to do with administration of the At Home program, which provides financial and respite support for the care of children of children with ongoing special medical needs. In 14 out of 15 of these cases the service provided adequate support in a timely manner. In the other case, the child was not approved for the program in a timely manner.

Of the remaining 9 cases:

- One child was not eligible for the At Home program, but the Ministry provided homemaker and other support services;

- One child received mental health services through the Ministry, and these services were found to be adequate and appropriate;

- In one case, a child protection report was investigated, the child was found to not be in need of protection, and the Ministry remained involved with the family at the mother's request for support purposes;

- In 6 cases, there were child protection concerns reported to the Ministry over a period of time.

In these 6 cases where child protection was at issue, there was one case of a child who would have been in care if proper practice had occurred. In 3 other cases, inadequate risk assessment leaves us with insufficient information to draw conclusions about whether these children should have been taken into care according to policy and standards.

Overall, child protection practice patterns seem to be improving. In 14 of 14 of the cases of children in care, as noted above, children were placed in care in a timely manner. In 2 of the 6 cases where the child was known to the Ministry but not in care, child protection investigations were timely and adequate. By comparison, in our 1999 report, we found that risk assessment was not carried out, or was carried out inadequately in 29 of 37 cases where it should have been an important aspect of case management because of clear abuse or neglect concerns.

Aside from the above findings, the case reviews of the 24 cases of children who received Ministry services, but were not in care showed:

- In 1 case, inadequate integrated case management was noted;

- In 3 cases, file recordings were inadequate;

- In 20 cases, Ministry services were found to be adequate.

3. Children in Need of Early Intervention and Support

Prevention and early support to parents who may be inexperienced, isolated or facing financial challenges, and without healthy support systems, are of critical importance in ensuring the well-being of infants and young children and in ensuring that problems are not allowed to compound over the years. This means that we must identify infants and young children at risk, put

services in place to support the parents by linking them to community services, teach basic parenting skills, and ensure that special needs children get the specialized help they will need to develop to their full potential.

Over time, effective early support services and prevention programs will reduce the number of older children who require intensive intervention for complex problems that have compounded over the years, and help prevent the deaths of children and youth.

Note: none of the 137 reviews being reported in this paper are reviews of SIDS deaths. Several such reviews have been completed, but have not yet been publicly reported on.

Information from the Fatality Reviews: Early Warning Signs

In 7 fatality reviews there was significant evidence of lack of attention to early warning signs of future difficulty. Common features of these 7 cases included:

- inadequate risk assessment,
- inadequate child protection interventions, and
- inadequate case management and coordination of services.

In these cases, service providers recorded early warning signs of significant risks to the child in their files:

- more than five years prior to death (4 cases)
- in the two years preceding death (3 cases).

In 4 of the cases where early warning signs of future difficulty were apparent, some combination of aggressive behavior, violence, criminal activity, mental health problems, including depression and psychosis, were noted. Most of these cases were identified by schools, but were not addressed or adequately followed-up.

Where early signs of trouble were not effectively responded to, most of the deaths were related to self-harm or risk-taking. There were:

- 3 suicide deaths,
- 3 motor vehicle fatalities,
- 1 natural death

Recommendations Relating to Prevention and Early Intervention

We made 18 recommendations that dealt specifically with issues or concerns related to the absence of and need for early intervention services, or related

policy and practice. Recommendations were made to MCF and other ministries and organizations including the Ministry of Health, the Ministry of the Attorney General, professional medical bodies and various hospitals, health boards, school districts, community agencies, federal government departments and aboriginal bands.

Recommendations related to prevention and early intervention have focused on:

- requests to medical College to review the quality of medical care provided to a number of children before their deaths;
- education and outreach programs for physicians and patients, particularly in the areas of diagnosis and management of childhood illnesses;
- the need for adequate resources and timely provision of counselling services; and
- more attention to issues of Fetal Alcohol Syndrome and Fetal Alcohol Effect, and the need for expectant mothers with substance abuse problems to be informed of family support services available through MCF.

The majority of responses received indicate that the issues or concerns raised in the case-specific recommendations are being, or will be addressed. A comprehensive, province-wide commitment to preventive community services for high-risk families, new families, and all others requiring early intervention services and supports is an ongoing need.

4. Deaths of Aboriginal Youth and Children

This year we completed 24 fatality reviews of deaths of aboriginal children and youth:

- 9 natural deaths
- 5 suicide deaths
- 4 motor vehicle deaths
- 2 accidental drowning deaths
- 1 homicide
- 1 accidental fire death
- 1 accidental hypothermia death
- 1 death from undetermined causes

Fifteen of these deaths occurred among youth in the 13 to 18 year old age group.

The following issues were observed in these 24 cases:

- lack of integrated case management (2 deaths),
- lack of risk assessment (3),
- inadequate or inappropriate services (4),
- lack of community resources and services in remote communities (2),
- inadequate child protection investigations (6), and
- alcohol and substance abuse by child/youth (6).

Recommendations Relating to Aboriginal Children and Youth

We have made 11 recommendations from the 2000 fatality reviews dealing with issues of direct provision of services to aboriginal children and youth. While these recommendations are generally accepted, and an intent to act on them has been indicated, systemic solutions often involve complex provincial/federal/band jurisdictional and funding questions that can undermine the urgent action that is required. This must be resolved to guarantee the health and safety of aboriginal children today.

5. Suicide Deaths

Over the past year, 15 suicide deaths have been reviewed. The age range among the group of youth whose suicide deaths were reviewed was from 13 to 18 years. Twelve of the 15 youth were 16 or older. In 8 cases, the youth was male, and in 7 cases, female.

The mechanism of suicide was as follows:

- 9 hangings
- 2 firearms
- 1 jump from a bridge
- 1 drug and alcohol poisoning
- 1 carbon monoxide poisoning
- 1 self-induced suffocation

Although the circumstances and personal factors that may give rise to youth suicide are diverse, studies have identified numerous risk and protective factors. The Children's Commission analyzes all suicides according to a framework published in a paper entitled, "Youth Suicide Prevention: A Framework for British Columbia," (White, 1998). Four clusters of risk and protective factors are identified as essential to our understanding of youth suicide. These four clusters, which interact together, are referred to as predisposing, contributing, precipitating and protective factors.

Although this framework helps provide guidance in the analysis of youth suicide, it is important to bear in mind that it does not represent an absolute or exhaustive list of factors which affect suicidal behaviour. Each individual experiences and responds to factors in different ways, and the impact of a particular matter may be known only to a small number of people, or perhaps only the individual in question. Suicide is a complex phenomenon and the path to suicidal behaviour is often difficult to predict.

Predisposing factors are best understood as those factors which ". . . set the stage for a vulnerability to suicide" (Adam, 1990; White, 1998). Predisposing factors identified in the 15 cases we reviewed included:

- history of depression - 6 cases
- previous suicide attempt – 4 cases
- history of social isolation and alienation - 4 cases
- history of suicidal ideation – 3 cases
- unresolved grief – 3 cases
- lack of meaningful connection to school – 3 cases
- community legacy of suicides – 3 cases
- psychiatric disorder – 2 cases
- history of depression in the family – 1 case
- family history of suicide – 1 case
- family history of suicide attempt – 1 cases
- early childhood loss and separation – 1 case
- history of a negative school experience – 1 case

Contributing factors are those which ". . . act to exacerbate the existing risk." (Adam, 1990; White, 1998). Contributing factors identified in the 15 cases we reviewed this year included:

- ongoing family conflict – 8 cases
- substance abuse – 6 cases
- substance abuse within family – 4 cases
- disruption during key transitional periods at school – 4 cases
- poor coping skills – 3 cases
- impulsive – 3 cases
- family instability – 3 cases
- family violence/abuse – 3 cases
- reluctance/uncertainty about how to help among key gatekeepers – 2 cases
- negative attitude toward seeking adult assistance – 1 case
- peer modeling of maladaptive behaviours – 1 case
- reluctance/uncertainty about how to help among school staff – 1 case
- access to firearms or other lethal methods – 1 case
- inaccessible community resources – 1 case

Precipitating factors refer to those factors which ". . . act as a trigger for predisposed persons" (Adam, 1990; White, 1998). Precipitating factors in the 15 cases may have included:

- personal failure – 6 cases
- school failure – 6 cases
- humiliation – 5 cases
- individual trauma – 4 cases
- loss of significant family member – 4 cases
- teasing/cruelty – 4 cases
- rejection by peers – 3 cases
- parental disciplinary crisis – 3 cases
- developmental crisis – 2 cases
- fear of parental disappointment – 2 cases
- death of peer, especially by suicide – 2 cases

Protective factors are those ". . . conditions which act to lessen the risk for suicide" (Adam, 1990; White, 1998). In this group of 15 cases, the following protective factors were noted:

- acceptance and support of peers – 3 cases
- presence of adults who believe in them – 3 cases
- previous experience with self-mastery – 2 cases
- family relationships – warmth and belonging – 2 cases
- parent involvement – 2 case
- easy temperament – 1 case
- adults modeling healthy adjustment – 1 case
- social competence – 1 case
- opportunities for participation – community – 1 case
- evidence of hope for the future – 1 case
- availability of resources – 1 case

Based on the above analysis, the most common factors observed included a history of depression, social isolation and alienation, substance abuse, ongoing family conflict, personal failure, school failure, and humiliation. It is noteworthy that many adolescents at one time or another experiences many of these issues. The paucity of protective factors in the lives of these 15 youth that killed themselves is also noteworthy.

In 4 of the 15 cases, no one in the youth's life was aware of suicide risk, and in 11 of the cases, there was awareness of risk.

In 4 of the 15 cases, there had been previous suicide attempts, and in all of these cases, mental health services were provided. In 2 of these 4 cases, the youth killed themselves only hours after a counselling session. In both of these instances, the counsellor/therapist had considered the youth to be high risk generally, but felt that there would not be an attempt in the near future because of a seemingly positive outlook at the time of the session.

In 2 cases there were concerns about mental health, but services were not provided. In one case, no referral was made even though the youth was known to be depressed. In another case, the youth could not be engaged in counselling.

In 3 of the cases where mental health services were not provided, the youths had expressed suicide ideation to peers, but this was not taken seriously.

In 7 of the 15 cases, the youths had received supports through their schools, in the form of counselling or a referral to mental health services.

In 5 of the 15 suicides, the youth was Aboriginal. Four of these youth were connected to their Aboriginal communities. Two of the cases were related; a male killed himself some months after his girlfriend had killed herself.

Suicide Recommendations

The Commission's suicide-related recommendations fall into the following seven broad groupings.

Risk Assessments

Recommendations in this area were directed primarily to the Ministry for Children and Families (MCF) and focused on the need for policy and practice to reflect both the requirement and need for suicide risk assessments of youth who had attempted suicide, or who had expressed suicide ideation. The Ministry responded to these recommendations by ensuring that new policies reflected the requirement for suicide risk assessment for at-risk youth, and that suicide risk factors would inform both child protection practice standards and guardianship standards.

Staff/Caregiver Training

Many training recommendations were made in conjunction with the recommendations regarding risk assessment in order to support the implementation of suicide risk assessments and enhance the ability of service providers to identify and support youth at risk for self-harm/suicide. In response to these recommendations MCF developed Suicide Intervention

Training for Child Protection Workers, Foster Parents and members of multidisciplinary teams working with children and youth. The suicide training provides an assessment framework for evaluating the child or youth that may be at risk for self-harm/suicide, and incorporates a risk assessment tool and methods for crisis intervention.

Schools are an important resource for identifying at-risk children and youth, and a critical protective factor in the lives of many of these children and youth. Training recommendations were directed to both the Ministry of Education (MOE) and to individual schools to enhance the training and knowledge of teachers. Many of the case-specific recommendations to individual schools and school districts resulted in increased opportunities for teachers and administrators to enhance their understanding of suicide risk factors and to improve their ability to identify at-risk children and youth. The MOE also developed training entitled *Suicide Awareness and Intervention for School Personnel* which was provided in a train-the-trainers format and an eight-page resource pamphlet on suicide risk factors entitled *Suicide-What You Need to Know: A Guide for School Personnel.*

This 8-page pamphlet provides facts about student suicide, information about who is at risk, and how to help. It includes a list of resources and contacts for more information and a sample suicide intervention protocol.

Integrated Case Management and Planning

Another body of Commission recommendations focused on the need for an integrated approach to the follow-up, management and planning for youth identified as at-risk for self-harm/suicide. The Ministry for Children and Families has developed information sharing protocols and integrated case management policy in order to improve the planning for all children and youth including those identified as at-risk for self-harm/suicide.

The *Integrated Case Management Policy* specifically includes:

- guidance to staff to share information with the youth's and family's care team in a timely manner;
- appropriate time frames for following up on the plans/tasks identified; and
- roles and responsibilities for each member of the team.

The Ministries of Education and Health as well as community agencies and health professionals also play key roles in integrated case management and have received Children's Commission recommendations related to improving information sharing and case planning among service providers. Improvements in these areas have included: increased use of in-service training amongst different professions, development of specific guidelines for case planning meetings, development of specific forms to be filled out and

faxed to other professionals regarding discharge planning and enhanced communication among local service providers through newly developed committees.

Age Appropriate Resources

Case-specific and systemic recommendations concerning the need for age-appropriate resources for suicidal children and youth have been made to the Ministry for Children and Families and specific local Health Regions. The MCF and identified Health Regions have taken some steps to improve youth mental health services at the local level. Some local improvements include: expansion of child psychiatry time for consultation, emergency response to youth 12 and up and education sessions to address mental health issues of adolescents and what services are currently available for referral.

Commission recommendations have also dealt with the pressing need for additional age-appropriate treatment beds. A recommendation made in 1998 as a result of a youth suicide recently culminated in the opening of a new, 10-bed adolescent psychiatric in-service facility at a local hospital.

Mental Health Follow-up

A number of case-specific recommendations focused on the need for follow-up, monitoring and re-assessment of youth that have been referred for mental health services. These recommendations have often been linked to integrated case management at the case level and specifically to the need for a case manager. Local Ministry staff and service providers have arranged meetings and planned how to ensure enhanced communication and more comprehensive follow-up of at-risk youth.

Public Awareness

A number of recommendations were made to media associations regarding the need to ensure that media coverage of suicides involving children and youth does not contain descriptions of how death was achieved. It was also requested that information pertaining to suicide prevention be included in any media coverage of suicide. The media associations indicated that their Code of Practice states that "journalists should approach assignments involving children with due regard for the well-being of the child or children in question" and that this would apply to coverage of a youth suicide. The associations also stated that they cannot dictate what newspapers should or should not publish, or compel their members to include information on suicide prevention in their stories. However, they also indicated that via letter all their members would be informed of the Commission's recommendations and concerns.

Prevention and Early Intervention

A number of recommendations addressed most specifically to individual schools encouraged the development of peer counselling resources and the introduction of suicide prevention programs into the schools. We found that in many of the cases reviewed a friend or peer of the youth had been aware of some earlier indication by the youth that they intended to harm themselves, but this information was never confided to an adult. Although the suicide intent was shared with peers, it was often not taken seriously by the youth's peers and so wasn't shared with someone who may have been able to intervene and help prevent the youth from committing suicide.

A number of schools have developed peer helper programs as a result of the Commission's recommendations. These peer helpers are receiving training in helping to identify at-risk youth, and are participating in the delivery of the suicide prevention programs being offered through the mandatory Career and Personal Planning curriculum of BC high schools.

6. Homicide Deaths

Seven of the 137 cases we completed in 2000 and have publicly reported were homicide deaths of children and youth.

Persons outside of their families murdered two youths; a rival gang member shot 1, and the other was stabbed by another youth that he did not know at an outdoor gathering.

Four of the homicide deaths involved children who died at the hands of their caregivers. In 3 cases, the perpetrator was a parent, in 1 case the perpetrator was a parent's partner. All of these perpetrators were incarcerated.

In 1 case, no perpetrator was identified.

7. Safety and Injury Prevention

Approximately 40% of the 137 deaths reviewed this year were the result of non-intentional injuries. These included:

- 29 youth motor vehicle deaths
- 5 child motor vehicle deaths,
- 1 pedestrian motor vehicle death
- 7 unintentional injuries in the home
- 9 recreational/sports injuries, and
- 10 drownings.

The following contributing factors were noted in the 29 youth motor vehicle deaths:

- excessive speed (18 deaths),
- driver inexperience/driving record (16),
- no safety restraint used (15),
- impaired drivers (12) (9 were underage youth),
- road and weather conditions (7),
- mechanical condition of vehicle (2),
- driver fatigue (4),
- risk taking behavior (6).

Most of these fatalities could have been prevented through safe driving practices.

Of the 12 cases involving driver impairment (9 of which were underage youth drivers), in 3 cases the impaired driver died. In the other 9 cases, the fatalities were passengers.

Of the 16 cases where driving inexperience was an issue, 8 of the drivers were unlicensed. In one case, the driver had 3 prior charges of driving without a license. In another case, concerns were expressed prior to the event about the driver's immaturity and irresponsibility. In another 2 cases, the drivers had histories of previous driving infractions.

Five of the deaths occurred in circumstances in which the driver was the sole occupant of the vehicle. In 5 cases, the driver and one passenger were in the car. In 13 cases, there were 3 occupants in the car. In the remaining 6 cases, there were more than 3 occupants in the car.

In 22 of the 29 cases, the youth who died was age 16 to 18.

Information from Fatality Reviews: Child Motor Vehicle Deaths

The following contributing factors were noted in the 5 child motor vehicle deaths:

- driver was a parent (4 cases)
- excessive speed (1)
- road and weather conditions (3)
- no seat belt (1)
- mechanical condition of the vehicle (1)

Misapplication of safety restraints or child safety seats was not noted in connection with any of these deaths.

Information from Fatality Reviews: Pedestrian Fatalities

One pedestrian death was reviewed. No contributing factors were noted in regard to this incident.

Note: Table 8 attached provides a statistical summary of deaths related to motor vehicles by age and regional location.

Information from Fatality Reviews: Unintentional Injuries in the Home

Seven of the deaths reviewed this year resulted from injuries sustained by children in or around the home:

- 4 children died in residential fires
- a toddler died of accidental poisoning after ingesting prescription drugs
- a toddler died in an accidental choking incident
- a youth accidentally hung himself in the backyard of his home

In all 4 fire-related deaths, there were no operational smoke detectors in the homes. In 2 of the cases, the fires were found to have been started by children playing with smoking paraphernalia.

Information from Fatality Reviews: Recreational Injury and Drowning Deaths

Of the 61 fatalities due to non-intentional injuries, nine involved injuries incurred during recreational activity. Of these nine fatalities,

Activities/equipment associated with these deaths included:

- 3 bicycle riding,
- 3 motorized vehicles (dirt bike, dune buggy, go-kart),
- 1 hiking
- 1 fall from a cliff
- 1 skateboarding

The 10 drowning incidents are summarized as follows:

- 3 occurred while swimming in rivers
- 3 occurred when children fell into rivers (1 was thrown from a car that was rolling)
- 3 occurred while swimming in lakes (2 were non-swimmers)
- 1 occurred when a young child fell into a swimming pool

In total, there were 19 deaths from recreational injuries and drownings. The following factors were associated with these deaths:

- 9 involved inadequate safety measures,
- 4 involved poor supervision by caregivers,

Recommendations Relating to Safety and Injury Prevention

Issues related to safety and prevention of non-intentional injury deaths in the fatality reviews resulted in 17 recommendations. These recommendations were made to many different types of ministries, crown corporations and agencies including the Ministries of Environment, Lands and Parks, Transportation and Highways, Education, Children and Families, ICBC, community agencies and associations, schools and school districts, health care agencies, and municipalities.

Our recommendations have been oriented towards practical policy, regulatory or engineering changes to increase safety, and toward measures to increase public awareness of proper safety practices.

Thirty-six of the fifty-five or 65% of the non-intentional injury deaths we reviewed were motor vehicle fatalities. Driver impairment, lack of seatbelt use, improper use of child restraint seats, driver fatigue, excessive speed and driver inexperience/driving record have been notable factors in these fatalities and have been the focus of recommendations in this area. Generally, responses indicate that these recommendations are being implemented or have been implemented.

Table 1

Child Fatalities 1988 to 2000
Birth to Age 18

Year of Death	Natural	SIDS	Accidental	Suicide	Homicide	Undetermined	All Causes
1988	354	75	158	28	14	1	**630**
1989	330	77	152	25	13	1	**599**
1990	360	64	146	12	11	1	**594**
1991	301	71	119	22	16	2	**531**
1992	305	62	118	23	15	8	**531**
1993	256	52	154	12	4	4	**483**
1994	322	41	119	21	25	5	**533**
1995	282	49	120	23	12	2	**488**
1996	281	26	108	15	15	4	**449**
1997	255	27	109	28	19	3	**442**
1998	228	15	90	16	2	9	**360**
1999	205	16	94	17	4	20	**357**
2000	190	9	82	19	10	34	**344**

* Source: BC Vital Statistics Agency
* There are more undetermined deaths in the more recent reporting years because classification of more recent deaths have not been finalized.

Table 2

Child Fatalities 1988 to 2000
Under 1 Year of Age

Year of Death	Natural	SIDS	Accidental	Suicide	Homicide	Undetermined	All Causes
1988	263	75	15	-	3	-	**356**
1989	263	74	12	-	-	1	**350**
1990	262	64	7	-	1	-	**334**
1991	215	70	4	-	3	-	**292**
1992	206	62	7	-	1	2	**278**
1993	183	48	16	-	-	2	**249**
1994	233	40	9	-	6	-	**288**
1995	220	49	6	-	-	-	**275**
1996	195	25	3	-	3	2	**228**
1997	165	27	6	-	1	3	**202**
1998	151	15	1	-	1	6	**174**
1999	134	16	3	-	1	4	**158**
2000	126	9	3	-	-	10	**148**

* Source: BC Vital Statistics Agency
* There are more undetermined deaths in the more recent reporting years because classification of more recent deaths have not been finalized.

Table 3

Child Fatality Rates Per 1,000 Live Births 1988 to 2000
Under 1 Year of Age

Year of Death	Natural	SIDS	Accidental	Suicide	Homicide	Undetermined	All Causes
1988	6.18	1.76	0.35	-	0.07	-	**8.36**
1989	6.06	1.70	0.28	-	-	0.02	**8.06**
1990	5.79	1.41	0.15	-	0.02	-	**7.38**
1991	4.73	1.54	0.09	-	0.07	-	**6.42**
1992	4.46	1.34	0.15	-	0.02	0.04	**6.03**
1993	3.98	1.04	0.35	-	-	0.04	**5.42**
1994	4.97	0.85	0.19	-	0.13	-	**6.15**
1995	4.71	1.05	0.13	-	-	-	**5.89**
1996	4.24	0.54	0.07	-	0.07	0.04	**4.96**
1997	3.72	0.61	0.14	-	0.02	0.07	**4.55**
1998	3.52	0.35	0.02	-	0.02	0.14	**4.06**
1999	3.21	0.38	0.07	-	0.02	0.10	**3.78**
2000	3.11	0.22	0.07	-	-	0.25	**3.66**

* There are more undetermined deaths in the more recent reporting years because some of the more recent deaths have not been classified.

** Fatality rates were calculated using data from the BC Vital Statistics Agency, and BC STATS.

Table 4

2000 Fatality Reports Released By The Children's Commission
Classification of Death By and Age of Child

Classification of Death	Under 1 Year	1 To 5 Years	6 to 12 Years	13 To 18 Years	Total
Accident	1	10	11	43	65
Homicide	1	3	1	2	7
Natural	13	7	17	10	47
SIDS	0	0	0	0	0
Suicide	0	0	0	15	15
Undetermined	0	1	0	2	3
Total Fatalities	***15***	***21***	***29***	***72***	***137***

Table 5

2000 Fatality Reports Released By The Children's Commission
Region By Classification of Death and Status

MCF Region	Accident	Suicide	Homicide	Undetermined	Natural	SIDS	Total	Child In Care	Rec'd MCF Services	Aboriginal
Out Of Province	4	0	0	0	0	0	4	0	0	0
Kootenays	1	0	3	0	1	0	5	0	2	0
Upper Fraser	2	0	0	0	5	0	7	1	4	1
South Fraser	10	2	1	0	9	0	22	3	4	2
Okanagan	5	2	0	0	2	0	9	1	1	0
Thompson/Cariboo	10	2	0	1	5	0	18	1	3	5
North	14	3	0	0	3	0	20	0	4	4
Central/Upper Island	6	1	0	0	5	0	12	0	4	3
Simon Fraser	7	1	1	1	6	0	16	5	2	4
Coast/North Shore	0	0	0	0	1	0	1	1	0	0
Vancouver/Richmond	4	3	1	0	8	0	16	2	5	2
Capital	1	1	0	0	2	0	4	0	1	3
Unknown	1	0	1	1	0	0	3	0	0	0
Total	***65***	***15***	***7***	***3***	***47***	***0***	***137***	***14***	***30***	***24***

* Note: Region is where the child's home was.

Table 6

All Fatality Reports Released By The Children's Commission Region By Classification of Death and Status (October 1, 1997 - December 31, 2000)

MCF Region	Accident	Suicide	Homicide	Undetermined	Natural	SIDS	Total	Child In Care	Rec'd MCF Services	Aboriginal
Out Of Province	6	0	0	0	1	0	7	0	0	0
Kootenays	14	0	6	1	8	3	32	3	8	1
Upper Fraser	11	1	2	1	19	1	35	3	16	6
South Fraser	27	8	6	3	16	7	67	10	18	7
Okanagan	25	5	4	2	8	4	48	3	18	3
Thompson/Cariboo	38	7	5	1	10	4	65	4	22	18
North	35	6	2	0	18	7	68	2	25	20
Central/Upper Island	19	5	9	2	22	8	65	7	22	25
Simon Fraser	20	3	4	4	17	8	56	11	16	9
Coast/North Shore	8	1	0	0	6	1	16	2	6	2
Vancouver/Richmond	27	9	2	1	20	7	66	12	22	15
Capital	9	4	0	2	8	3	26	3	8	8
Unknown	1	0	1	1	0	0	3	0	0	0
Total	***240***	***49***	***41***	***18***	***153***	***53***	***554***	***60***	***181***	***114***

* Note: Region is where the child's home was.

Table 7

2000 Released Fatality Reports: Children In Care
Classification of Death By Age of Child

Classification of Death	Under 1	1 To 5 Years	6 To 12 Years	13 To 18 Years	Total Released
Natural	2	1	3	3	9
Accident	0	0	0	4	4
Suicide	0	0	0	0	0
Homicide	0	0	0	0	0
Undetermined	0	1	0	0	1
SIDS	0	0	0	0	0
Total	***2***	***2***	***3***	***7***	***14***

* Fatality Reports Released in 2000 (N=137)

** Note: Region where child's home was.

Table 8

2000 Released Fatality Reports: Motor Vehicle Deaths
MCF Region By Age of Child

MCF Region	Under 1	1 To 5 Years	6 To 12 Years	13 To 18 Years	Total Released
Out of Province	0	0	0	2	2
Kootenays	0	0	0	1	1
Upper Fraser	0	0	0	0	0
South Fraser	0	0	1	3	4
Okanagan	0	0	0	4	4
Thompson/Cariboo	0	0	1	4	5
North	0	2	1	6	9
Central/Upper Island	0	0	0	2	2
Simon Fraser	0	0	0	4	4
Coast/North Shore	0	0	0	0	0
Vancouver/Richmond	0	0	0	2	2
Capital	0	0	0	0	0
Unknown	0	0	0	1	1
Total	***0***	***2***	***3***	***29***	***34***

* Fatality Reports Released in 2000 (N=137)

** Note: Region where child's home was.